UNITED
NATIONS

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Secretariat

ST/IC/1998/39
22 May 1998

INFORMATION CIRCULAR*

To: Members of the staff at Headquarters

From: The Controller

Subject: RENEWAL OF THE HEADQUARTERS MEDICAL AND DENTAL INSURANCE PLANS EFFECTIVE 1 JULY 1998, AND ANNUAL ENROLMENT CAMPAIGN, 1 - 5 JUNE 1998**

General

1. The purpose of the present circular is to announce:

[a] Changes in the premium and contribution rates (see page 2) which will come into effect on 1 July 1998 as follows:

- **AETNA Open Choice PPO - no change in premium levels;**
- **Blue Cross Blue Choice PPO - 12.5 per cent increase in premium levels;**
- **HIP HMO - 6 per cent increase in premium levels;**
- **Kaiser HMO - 13.1 per cent increase in premium levels;**
- **Dental plan - (see [b] below), no change in premium levels.**

[b] The introduction, with effect from 1 July 1998, of the CIGNA Dental PPO plan. This plan replaces the GHI dental plan which will terminate on 30 June 1998. Staff members enrolled in the GHI plan will be automatically enrolled in the CIGNA Dental PPO plan effective 1 July 1998, unless they choose to cancel their dental coverage. New CIGNA identification cards will be issued. Staff members not currently enrolled in the GHI plan, may enrol themselves and their eligible family members in the new CIGNA plan during the course of the annual enrolment campaign. A description of the benefits and provider network of the CIGNA plan is set out in annex V to this circular;

[c] Modifications in the out-patient mental health benfits under the Aetna PPO plan and in the chiropractic and acupuncture benefits under the Blue Cross BlueChoice PPO plan. These benefit changes are described in annex I and annex II, respectively.

2. Annexes I to VIII to the present circular set out plan outlines and benefit summaries. These annexes are listed in paragraph 14.

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* Expiration date of the present information circular: 30 June 1999.

** Personnel Manual index No. 6171.

HEADQUARTERS MEDICAL AND DENTAL INSURANCE
SCHEDULE OF MONTHLY PREMIUMS a/ AND CONTRIBUTION RATES b/
(Effective 1 July 1998)

Type of coverage		Aetna Open Choice	Blue Cross BlueChoice	HIP/HMO	Kaiser/HMO	CIGNA Dental with medical plan	CIGNA Dental alone
Staff member only							
Premium rate	($)	319.34	229.84	185.13	214.63	23.14	23.14
Contribution rate	(%)	2.76	2.00	1.62	1.85	0.19	0.29
Staff member and one child							
Premium rate	($)	614.51	458.60	366.49	429.28	55.15	55.15
Contribution rate	(%)	4.66	3.53	2.69	3.28	0.39	0.59
Staff member and spouse							
Premium rate	($)	614.51	458.60	366.49	429.28	55.15	55.15
Contribution rate	(%)	4.66	3.53	2.69	3.28	0.39	0.59
Staff member and two or more eligible family members							
Premium rate	($)	775.05	665.84	540.58	579.51	115.59	115.59
Contribution rate	(%)	5.24	4.53	3.59	3.88	0.77	1.16

a/ The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see below) by the related percentage of salary.

b/ "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. Actual contributions are capped at 85 per cent of the corresponding premium.

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Annual enrolment campaign

3. The annual enrolment campaign at Headquarters will be held from 1 to 5 June 1998 at the offices of the Insurance, Claims and Compensation Section (ICCS) of the Office of Programme Planning, Budget and Accounts, room S-2765, between the hours of 10 a.m. and 5 p.m. STAFF MEMBERS AT HEADQUARTERS MUST COME IN PERSON TO THE INSURANCE, CLAIMS AND COMPENSATION SECTION OFFICE TO COMPLETE THE APPLICATION FORM AND OTHER FORMS AS NECESSARY. The staff of the Insurance, Claims and Compensation Section will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff. In addition, representatives of the insurance companies will be on hand on 1 to 3 June, and CIGNA on 4 and 5 June also, to provide information about the various insurance plans offered. The insurance company desks will be located in the staff activities area near the Secretariat cafeteria entrance.

4. **Staff members are reminded that this will be the ONLY opportunity until June 1999 to enrol in the United Nations medical and dental insurance plans.** This is also an opportunity to review current health insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans, as may be necessary or desirable. Staff members who are satisfied with their coverage do not need to take any action at this time.

5. The medical and dental plans being offered during the June campaign and the pages on which plan outlines may be found are as follows:

[a] Aetna Open Choice (p.7);

[b] Blue Cross BlueChoice (p.23);

[c] Health Insurance Plan of Greater New York, Health Maintenance Organization (HIP/HMO) (p. 33);

[d] Kaiser Foundation Health Plan of the Northeast, Health Maintenance Organization (Kaiser/HMO) (p. 36);

[e] CIGNA Dental PPO plan (CIGNA) (p. 39).

6. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 1998. **A change in enrolment between the Aetna and Blue Cross plans will oblige the participant to meet the annual out-of-network deductible in the new plan.**

Eligibility and enrolment rules and procedures

7. Heretofore, the annual information circular setting out the premium levels, contribution rates and description of benefits pertaining to the Headquarters health plans also included sections dealing with eligibility criteria and enrolment rules. By Secretary-General's bulletins ST/SGB/1997/1 and ST/SGB/1997/2 dated 28 May 1997, the Secretary-General introduced a new system for the promulgation of administrative issuances and information circulars. Therefore, in line with the new system, the present circular is confined to the announcement of premium, contribution and benefit information relating to the Headquarters plans. A separate administrative

instruction will be issued in due course which will set out eligibility criteria and enrolment rules and procedures governing all United Nations contributory health insurance plans. Until the new administrative instruction is issued, the eligibility criteria and enrolment rules pertaining to the Headquarters plans as set out in information circular ST/IC/1997/32 dated 28 May 1997 (paras. 7-16) will remain in effect.

Cessation of coverage of staff member and/or family members

8. The Insurance, Claims and Compensation Section should be notified immediately of changes in the staff member's family that result in a family member ceasing to be eligible, e.g., a spouse upon divorce or a child reaching the end of the calendar year in which the age of 25 years is attained, marrying or taking up full-time employment. The responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") RESTS WITH THE STAFF MEMBER. Staff members who wish to discontinue their coverage or that of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. Such terminations of coverage should be communicated to the Insurance, Claims and Compensation Section directly. It is in the interest of staff members to notify the Insurance, Claims and Compensation Section promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance, Claims and Compensation Section.

After-service health insurance

9. Staff members are reminded that, among the eligibility requirements for ASHI coverage, the ASHI applicant must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized ASHI participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the ASHI staff member at the time of separation are eligible for continued coverage under the programme. After-service participants are reminded that the restriction set out in paragraph 4 above, to the effect that staff members may switch from one insurance plan to another only during the period of the annual enrolment campaign, does not apply fully to them. Full details on the eligibility requirements and administrative procedures relating to ASHI coverage are set out in administrative instruction ST/AI/394, dated 19 May 1994.

Conversion privilege

10. Participants who cease employment with the United Nations and are not eligible for after-service benefits may arrange for medical coverage under an individual contract. This provision applies to all medical plans currently offered. The conversion privilege means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. In general, unless the separating staff member has had a history of poor health, exercising the conversion

privilege will be more costly than acquiring new insurance coverage. IN ADDITION, THE CONVERSION PRIVILEGE DOES NOT MEAN THAT THE SAME INSURANCE PREMIUM RATES OR SCHEDULE OF BENEFITS IN EFFECT FOR THE UNITED NATIONS GROUP POLICY WILL BE OFFERED IN RESPECT OF INDIVIDUAL INSURANCE CONTRACTS. It should be noted, moreover, that the conversion privilege may be exercised only for separating staff who continue to reside in the United States as the insurers cannot write individual policies for persons residing abroad. In all cases, the conversion privilege must be exercised WITHIN 31 DAYS OF THE DATE OF SEPARATION. Details concerning conversion to individual policies under Aetna and Blue Cross BlueChoice may be obtained from the Insurance, Claims and Compensation Section, room S-2765. Details concerning conversion to individual policies under HIP and Kaiser should be obtained from those companies directly. The dental plan does not have a conversion option.

Claims and benefit inquiries and disputes

11. Although the staff of the Insurance, Claims and Compensation Section is available to assist staff members in administrative matters concerning participation in the various Headquarters insurance plans and problematic claims issues, claims questions should always be taken up in the first instance directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex VIII to the present circular.

12. Staff members are reminded that the plan descriptions set out in annexes I to V constitute summaries of the benefits available under the respective plans. Every care has been taken to ensure that the plan summaries are as comprehensive as possible. However, each of the plans is subject to certain exclusions and limitations which are set out in the respective plan description booklets and in the policy contract. In the event of a claim dispute with any of the insurance carriers or plan administrators concerned, the resolution of such dispute will be guided by the terms and conditions of the policy contract in question and the final decision will rest with the insurance carrier or plan administrator, not with the United Nations. The policy contracts with the insurance carriers or plan administrators are available for review by subscribers, as may be necessary, by appointment at the offices of the Insurance, Claims and Compensation Section, room S-2765.

Headquarters health insurance plans: outlines and summaries of benefits

How plans are costed

13. The United Nations policies with Aetna, Blue Cross and CIGNA are "experience-rated". This means that the premium cost each year of the Aetna, BlueChoice and CIGNA Dental plans is based on the level of claims incurred in the prior year and expected rates of utilization and medical cost inflation for the renewal period. In effect, the costs of these plans (claims incurred plus administrative expenses) are borne collectively by participants in these schemes. In a year following a period of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been relatively moderate, the premium increase in the subsequent year will be correspondingly moderate. The two health maintenance organization (HMO) plans, HIP and Kaiser, are "community-rated". This means the premium costs are based on the combined experience of all employers participating in these schemes, not just the United Nations, and are approved by the relevant state insurance authorities. It

should be emphasized, particularly with respect to the three experience-rated plans, that prudent utilization by all participants concerned will have the effect of moderating premium costs for the benefit of all.

Plan outlines and benefit summaries

14. Outlines of the health insurance plans offered as well as summaries of benefits of each plan are set out in the following annexes:

		Page
I.	Aetna Open Choice	7
II.	Blue Cross BlueChoice	23
III.	HIP/HMO	33
IV.	Kaiser/HMO	36
V.	CIGNA Dental PPO	39

In addition, information regarding the World Access emergency facility for Aetna and BlueChoice subscribers, a listing of participating Aetna and BlueChoice pharmacies as well as a listing of insurance carrier addresses and telephone numbers are set out in the following annexes:

VI.	World Access	45
VII.	Aetna and BlueChoice, participating pharmacies	46
VIII.	Insurance carrier addresses and telephone numbers for claims and benefit inquiries	47

15. Lists of participating providers under the Aetna, Blue Cross and CIGNA PPO plans are available at the offices of the Insurance, Claims and Compensation Section (ICCS), room S-2765. In addition, staff members are encouraged to utilise the provider search facilities which can be accessed through the ICCS home page on the UN Intranet. Just click on "Insurance" on the Intranet home page.

Annex I

AETNA "OPEN CHOICE" PLAN

Plan outline

The Aetna Open Choice health benefits plan (Aetna) offers worldwide coverage for hospitalization and surgical, medical and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or non-network provider.

Aetna Open Choice is a dual-track plan that offers all the benefits of the traditional Aetna indemnity plan plus the option of a preferred provider organization (PPO) network of physicians and other medical providers nationwide. This means that participants can choose, if they wish, to go to a doctor who is in-network and pay only $10 per visit or treatment without any further need to file a claim with Aetna. Alternatively, participants may opt to receive treatment from any physician not in the network and be reimbursed by Aetna in the usual way, subject to the annual deductible and the normal co-insurance. A comprehensive summary of the plan, both the in-network and the non-network (traditional indemnity) benefits are set out in outline form commencing on page 9.

Under the non-network (traditional) track of the new Aetna plan, when a participant has met the annual deductible of $125 per individual and $375 per family and a further $1,000 per covered individual in co-insurance (20 per cent of $5,000 of recognized expenses), Aetna will reimburse all further claims incurred in the year, subject to the provision that they be "reasonable and customary", at 100 per cent. The deductible and co-insurance requirement must be met each calendar year. There is no lifetime reimbursement limit under the Aetna plan. When a participant is treated by a network physician, paying the fixed $10 co-payment for each visit, it is important to note that those $10 amounts do not count towards meeting the $1,000 out-of-pocket expense limit referred to above. This is so because, under the in-network track of the plan, medical expenses are already considered to have been paid at 100 per cent to the network provider after the participant has met the fixed $10 co-pay.

Premium

There will be no increase in the total monthly premium of the Aetna plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1998. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

The package of benefits under the Aetna Open Choice plan is itemized in the plan summary (pp. 9-16). In line with federal legislation which mandates that mental health benefits may not be subect to anuual maxima if benefits for the treatment of physical conditions have no comparable limitations, the annual cap of $3,216 relating to out-patient mental health treatment is removed with effect from 1 July 1998. The revised benefit for out-patient mental health is set out under section C of this annex, on page 20 below.

Aetna claims

The address to which Aetna claim forms should be sent is as follows:

Aetna Life Insurance Company
Unit 73
3541 Winchester Road
Allentown, PA 18195-0501

Plan Features	*Preferred Benefits (In-Network)*	*Non-Preferred benefits (Out-of-network)*
Plan deductible	$0 Individual $0 Family	$125 Individual $375 Family
Co-insurance limit	$1,000 Individual; $3,000 Family	
Lifetime maximum	Unlimited	Unlimited
Physician services (except Mental health/ALC/Drug)		
Office visits (non-surgical)	100% after $10 co-payment	80% after deductible
Specialist (office visits)	100% after $10 co-payment	80% after deductible
Routine physicals/ immunizations Well-baby care to age 7; 1 exam every 24 months for ages 7 to 19; including immunizations	100%	100%
Routine physicals/ immunizations Children age 19+ and adults: 1 routine exam every 24 months. (One routine exam annually for members age 65 and older); including immunizations.	100% after $10 co-payment	80% after deductible
Routine mammography (no age limit)	100%	80% after deductible; if performed on an in-patient or in the outpatient department of a hospital

Plan Features	*Preferred Benefits (In-Network)*	*Non-Preferred benefits (Out-of-network)*
Routine ob/gyn exam (All routine exam per calendar year; including 1 pap smear and related fees)	100% after $10 co-payment	80% after deductible
Surgery	100%	80% after deductible
Physician in-hospital services	100%	80% after deductible
Allergy testing and treatment (given by physician)	100% after $10 co-payment	80% after deductible
Allergy injections (not given by physician)	100%	80% after deductible
Other physician services	100%	80% after deductible
Diagnostic X-ray and laboratory (other than physician's office)	100%	80% after deductible
Hospital services In-patient coverage	100%	100%
Outpatient coverage	100%	100%
Emergency room (based on symptoms)	100% Covers sickness within 12 hours' onset; surgery, accident within 72 hours	100% Covers sickness within 12 hours' onset; surgery, accident within 72 hours
Non-emergency use of the emergency room (examples of conditions: skin rash, earache, bronchitis, etc.)	80%	80% after deductible

Plan Features	*Preferred Benefits (In-Network)*	*Non-Preferred benefits (Out-of-network)*
Acupuncture* (for chronic pain treatments only, services must be rendered by a medical doctor or licensed acupuncturist)	100% after $10 co-payment up to a maximum benefit of $1,000	80% after deductible up to a maximum benefit of $1,000
Spinal manipulation*	100% after $10 co-payment up to a maximum benefit of $1,000	80% after deductible up to a maximum benefit of $1,000
Mental health services In-patient coverage**	100%	100% after deductible
	Maximum 90 days per calendar year*	Maximum 90 days per calendar year*
Outpatient coverage	100% maximum of 50 visits per calendar year***	80% after deductible up to maximum of 50 visits per calendar year***
Crisis intervention	100% up to 3 visits per calendar year*	80% after deductible up to 3 visits per calendar year*

*** Preferred and non-preferred benefits are combined for a maximum of $1,000 per calendar year.**

**** See Focused Psychiatric Review (p.19)**

***** Maxima are for the calendar year whether preferred or non-preferred, or a combination of the two.**

Plan Features	*Preferred Benefits (In-Network)*	*Non-Preferred benefits (Out-of-network)*
Alcohol/drug abuse In-patient coverage	100%	100% after deductible
Maximum	60 days per calendar year*	60 days per calendar year*
Lifetime maximum	2 confinements*	2 confinements*
Outpatient coverage	100% Up to 60 visits per calendar year* (includes 20 visits* for counselling)	80% after deductible Up to 60 visits per calendar year* (includes 20 visits* for counselling)
Maternity (coverage includes voluntary sterilization and voluntary abortion)	100% after $10 co-payment; 100% voluntary sterilization if performed in-patient or in the outpatient department of a hospital	80% after deductible; 100% voluntary sterilization if performed in-patient or in the outpatient department of a hospital
Prescription drug	100% after 15% co-payment; up to 30-day supply at participating pharmacies; co-payment maximm $15	80% after deductible

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* **See Focused Psychiatric Review (FPR) (p.19)**

** **Maxima are for the calendar year whether preferred or non-preferred, or a combination of the two.**

Plan Features	*Preferred Benefits (In-Network)*	*Non-Preferred benefits (Out-of-network)*
Prescription drug	100% after $10 co-payment; up to 90-day supply from participating Mail Order vendor; when brand name is requested, member must pay co-payment plus difference between brand and generic price unless "DAW" is written on prescription.	
OTHER BENEFITS		
Skilled nursing facility	100% up to 365 days per calendar year	
Home health care	100% 320 visits per calendar year (no prior confinement required)	100% for first 200 visits; 80% after deductible for additional 120 visits per calendar year (no prior confinement required)

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Plan Features	*Preferred Benefits (In-Network)*	*Non-Preferred benefits (Out-of-network)*
Ambulance*	100%	
Private-duty nursing (restricted benefit on an in-patient basis)	100% up to 70 eight-hour shifts per calendar year	80% after deductible up to 70 eight-hour shifts per calendar year
Hospice care In-patient and outpatient coverage	100% Up to 210 days for both in-patient and outpatient services	
Bereavement counselling	100% Up to 5 visits	
Short-term rehabilitation Physical, occupational therapy	100%	80% after deductible
Speech therapy	80% Deductible does not apply**	
Hearing aid Hearing device*	80% Deductible does not apply Maximum $750, 1 hearing aid per ear every 3 years	

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* **There are no preferred (or in-network) providers of these services at the present time.**

** **When services are rendered by a participating provider, 100 per cent reimbursement applies.**

Plan Features	*Preferred Benefits (In-Network)*	*Non-Preferred benefits (Out-of-network)*
Evaluation and audiometric exam	100% after $10 Co-payment	Maximum $100, 1 exam every 3 years, must be examined by otolaryngologist or state-certified audiologist
Outpatient dabetic self-management education programmes	80% deductible does not apply*	
Durable medical equipment	80% deductible does not apply**	
Vision care Optical lenses (including contact lenses)	80% deductible does not apply; maximum $60 for any 2 lenses in a 24-month period	
Vision one programme	Savings up to 65% on frames; up to 50% on lenses; about 20% on contacts at participating Cole Vision Centres. Refer to separate handout for details.	
In-patient pre-certification	Provider-initiated	Not required

*** If services are rendered in a hospital, 100 per cent reimbursement applies with no co-payment. If rendered in an in-network doctor's office, 100 per cent reimbursement with $10 co-payment applies.**

**** If services are rendered by a participating provider or within a hospital setting, 100 per cent reimbursement applies with no co-payment.**

Plan Features	*Preferred Benefits (In-Network)*	*Non-Preferred benefits (Out-of-network)*
Focused psychiatric review* Penalty for failure to pre-certify in-patient psychiatric treatment	None	$100 penalty; applies per occurrence
Second surgical opinion	Not required, however covered at 100% after $10 co-payment	Not required, however covered at 100% after deductible
Claim submission	Provider-initiated	Member-initiated

*** In-patient mental health services, including alcohol/substance abuse treatment, are provided under the Focused Psychiatric Review (FPR) programme. For in-patient confinements, pre-certification is required. For in-network services, the network provider is responsible for pre-certification. For non-network services, either the physician or the staff member must pre-certify the confinement.**

"Vision One" eyecare discount programme

The Vision One programme offers subscribers and covered family members immediate discounts on eyecare needs including frames, lenses and contact lenses. This programme is an addition to, not a substitute for, the existing optical lens benefit which will be continued as before. The programme is available at over 2,500 locations nationwide including the optical centres in national retail outlets such as Sears, JC Penney and Montgomery Ward and many of the Pearle Vision Centers as well as selected independent providers/offices. To obtain the discounts available under this programme, it is only necessary to show the provider the Aetna identification card at the time of the visit. The provider will apply the discounts to any purchases made and will accept valid prescriptions from any licensed optometrist or opthalmologist. The Vision One programme may be used as often as desired. As it is simply a discount programme, claim forms are not required. For more details and outlet locations, call Vision One at (800) 793-8616, weekdays from 9:00 a.m. to 9:00 p.m. and Saturdays from 9:00 a.m. to 5:00 p.m. A schedule of costs and typical savings, is set out below.

Benefits	Vision One cost
Frames	
Priced up to $60.00 retail	$16.00
Priced from $61.00 to $80.00 retail	$26.00
Priced from $81.00 to $100.00 retail	$36.00
Priced from $101.00 to $200.00 retail	50.0%
Lenses - per pair (uncoated plastic)	
Single vision	$25.00
Bifocal	$45.00
Trifocal	$55.00
Lenticular	$95.00
Lens options - per pair (add to lens prices above)	
Standard-Progressive (no line bifocals)	$50.00
Polycarbonate	$30.00
Scratch resistant coating	$12.00
Ultraviolet coating	$12.00
Solid or gradient tint	$ 8.00
Glass	$15.00
Photochromic	$30.00
Anti-reflective coating	$35.00
Transitions	$55.00

Benefits

Eye examinations (by licensed independent doctors of optometry)

Eyeglasses - $33.00
Contact - $10.00 off normal fee

Contact lenses (two ways to save on contact lenses)

1. Visit the more than 2,500 locations nationwide and save 20 per cent discount from regular retail prices.

2. Use the Vision One Contact Lens Replacement Programme for additional savings and convenience.

Call (800) 391-5367 for this service.

Dispensing fee

The fee for fitting and dispensing (including unlimited eyeglass adjustments) is only $10.00.

Acupuncture benefits

The Aetna Open Choice plan provides benefits for acupuncture treatment rendered by a medical doctor or licensed acupuncturist, up to a maximum benefit of $1,000 per calendar year. While this benefit will be described in the plan description book to be made available to all participants, the scope of the benefit may be summarized as follows:

Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension headache
- Migraine headache
- Psychalgia
- Neuralgia
- Backache
- Lumbago
- Muscle spasm
- Bursitis

Acupuncture treatment in lieu of anaesthesia has been recognized as a reimbursable procedure by Aetna under the traditional plan. This benefit, as all other benefits under the traditional plan, will be maintained under Aetna Open Choice.

Mental and nervous and substance abuse benefits

A. In-patient benefits

All hospitalization for mental and nervous and substance abuse conditions is subject to the Focused Psychiatric Review (FPR) procedure. STAFF MEMBERS ARE ASSURED THAT THE FPR PROGRAMME IS CONDUCTED IN THE STRICTEST CONFIDENCE. The procedure is as follows:

1. Prior to a non-emergency hospital admission, Aetna must be informed of the intended admission. This is accomplished by placing a telephone call to a toll free Aetna number [**(800) 424-1601**]. This call will be taken by a member of the Aetna FPR team. The telephone call may be placed by the subscriber himself or herself, the attending physician, a family member, or any other person acting for the patient to be hospitalized.

2. The initial information required by Aetna in order to pre-certify the admission includes the subscriber's identification number (payroll index number), the reason for the admission, the physician's name, address and telephone number, the hospital name, address and telephone number, and the scheduled admission date.

3. The FPR specialist then contacts the attending physician to review the information prior to certification of the admission. If the attending physician makes the original call to the 800 number, this step will be accomplished at that time. The FPR specialist certifies a certain number of in-patient days, if appropriate, and develops a plan of regular follow-up visits with the attending physician. Failure to pre-certify an in-patient admission for mental and nervous and substance abuse treatment will result in a $100 reduction of the benefit amount paid.

4. An emergency admission, which cannot be pre-certified before the confinement begins, must be called in to the Aetna FPR number within 48 hours of the emergency admission.

B. In-patient mental and nervous and substance abuse care

1. The full cost (semi-private accommodation) of 30 days of hospitalization for the treatment of mental and nervous disorders. Hospital confinements beyond 30 days are reimbursed subject to the normal deductible and co-insurance provisions.

2. The full cost (semi-private accommodation) of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation, limited to two 30-day benefit periods in a lifetime. Continuous confinement of up to 30 days beyond this 30-day limit is subject to the provision under paragraph 3 below.

3. Coverage for up to 30 days of hospitalization for substance-abuse (alcohol and/or drug) rehabilitation after the 30-day hospitalization benefit described in the paragraph above has been exhausted. This benefit is available twice in a lifetime and is applicable only as a continuation of each of the two 30-day hospitalization periods provided under paragraph 2 above.

C. Out-patient mental and nervous and substance abuse care

1. A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric social worker). If treatment is obtained from a network provider, the plan pays 100 per cent of the cost. If the provider does not participate in the PPO network, reimbursement will be at 80 per cent of the reasonable and customary fee level for the area in which the services are rendered, and will be subject to the annual deductible. The 50 visit annual maximum is for network and non-network treatment combined. Co-insurance payments made in respect of out-of-network treatment will not be applied to the $1,000 annual co-insurance maximum.

2. Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse.

Discount prescription drug programme (Aetna Pharmacy Management)

A. The Aetna Pharmacy Management (APM) prescription drug programme, along with its mail order affiliate, Walgreens Healthcare Plus, reimburses, at significant savings, the cost of prescription drugs obtained from participating pharmacies and from the Walgreens Healthcare Plus mail order facility.

1. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a specific brand be dispensed by indicating "Dispense as written" or "DAW", the generic equivalent drug will be provided by the pharmacist, and the discount off the AWP can be as high as 50 per cent, depending on the generic equivalent supplied. The discount for maintenance drugs obtained by mail through the Walgreens Healthcare Plus mail order facility will range from 18 per cent to as high as 50 per cent off AWP depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

2. The procedure under which prescription drugs are reimbursed through the Aetna Pharmacy Management Programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice along with the Aetna card (a listing of participating pharmacies in the New York metropolitan area may be found in annex VII).

The pharmacist will fill the prescription for up to a 30-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) based upon the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

3. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through Walgreens Healthcare Plus mail order facility which will charge a fixed $10 co-insurance. The Walgreens order form supplied with the Aetna card should be utilized for ordering prescription drugs by mail. A new order form will be sent along with the filled prescription.

4. It should be noted that if a participant wishes to receive the brand-name drug even though the physician has not specifically prescribed the brand-name, the participating pharmacy will charge a participant 15 per cent of the cost of the brand-name drug, but not more than $15 per prescription. In cases in which a brand-name maintenance drug is ordered through the Walgreens mail order facility even though it has not been specifically prescribed, Walgreens will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

B. As the Aetna prescription drug programme benefit is being administered separately by Aetna Pharmacy Management, the normal annual deductible under the Aetna plan will NOT be applied to prescription drugs. At the same time, however, prescription drug expenses will NOT count towards meeting the annual co-insurance limit of $1,000. Prescription drugs obtained outside the United States or within the United States but NOT through either the Aetna pharmacy network or the Walgreens mail order facility will be reimbursed in the normal manner through the submission of the standard claim form to the Aetna claims office in Allentown, Pennsylvania. In such cases, the normal annual deductible will have to be met before reimbursement is made, as well as the 20 per cent co-insurance, which will count towards meeting the annual limit of $1,000.

Other provisions

A. Special conditions apply to certain medical procedures for injury-related dental and cosmetic injury, for convalescent facility expenses and for treatment of temporo-mandibular joint syndrome (TMJ). Participants are advised to consult the Aetna claims office in advance of commencing treatment for these conditions.

B. Unlimited overall lifetime reimbursement benefits.

C. Certain expenses are not covered under the Aetna plan. These comprise expenses for services or supplies not deemed by Aetna as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are

not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Aetna as reimbursable under the plan, Aetna Member Services should be contacted at (800) 784-3991 prior to commencement of treatment. In addition, the Aetna policy contract document is on file in the offices of the Insurance, Claims and Compensation Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

D. If Aetna denies a claim in whole or in part, the subscriber will receive a written notice from Aetna. This notice will explain the reason for the denial and the appeal procedure. The request for review must be submitted in writing within 60 days of receipt of the notice. The subscriber should include the reasons for requesting the review and submit the request to the Aetna Allentown Claim Office. Aetna will review the claim and ordinarily notify the subscriber of its final decision within 60 days of receipt of the request. If special circumstances require an extension of time, notification will be given to that effect.

E. Subscribers should note that claims for reimbursement must be submitted to Aetna no later than two years from the date on which the medical expense was incurred. CLAIMS RECEIVED BY AETNA LATER THAN TWO YEARS AFTER THE DATE ON WHICH THE EXPENSE WAS INCURRED WILL NOT BE ELIGIBLE FOR REIMBURSEMENT.

Annex II

BLUE CROSS BLUECHOICE

Plan outline

The BlueChoice plan blends the features of a full indemnity (fee-for-service) plan with the advantages of an extensive network of participating providers covering most medical specialties. When treatment is rendered by a preferred (in-network) provider, the only charge to the participant is $10 (except for mental health/substance abuse treatment). On the other hand, the participant may equally be treated by a physician who is not a participating practitioner in the plan. Medical services rendered by non-participating (out-of-network) providers will be reimbursed subject to a deductible and 20 per cent co-insurance. The deductible and 20 per cent co-insurance requirement must be met each calendar year.

A network of physicians covering New York City and the New York metropolitan area participate in the BlueChoice plan and accept as payment a fee schedule arranged with Blue Cross. No deductible has to be met, but instead, the participant pays a $10 co-payment for each visit ($25 for mental health). If, however, a participating physician refers a patient to another provider who is non-participating, the deductible and 20 per cent co-insurance will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider (50 per cent co-insurance for mental health visits). A number of diagnostic laboratories are participating providers under the BlueChoice plan. When any laboratory tests are required, it is important that the physician be told to direct the tests to a participating laboratory, if possible. If this is done, the cost of the laboratory test will be paid in full and will not be subject to the normal deductible and co-insurance.

Premiums

There will be a 12.5 per cent increase in the total monthly premium of the BlueChoice plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1998. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

New acupuncture benefits

Formerly, the BlueChoice plan provided benefits for acupuncture treatment rendered by a medical doctor (MD), a doctor of osteopathy (DO) or a doctor of dental surgery (DDS) provided that the practitioner is also a licensed acupuncturist. With effect from 1 July 1998, Blue Cross will also recognize for reimbursement acupuncture treatment provided by a licensed acupuncturist who is not a doctor.

Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension headache
- Migraine headache
- Psychalgia
- Neuralgia
- Backache
- Lumbago
- Muscle spasm
- Bursitis

Out-of-network provider utilization

Should the participant choose to be treated by a non-participating (out-of-network) provider or be referred by an in-network physician to an out-of-network provider, BlueChoice will pay 80 per cent of the reasonable and customary charge after the participant has met a $150 deductible per individual/$450 per family. After $900 of unreimbursed reasonable and customary medical expenses have been paid by the participant in a given year, further reasonable and customary expenses will be reimbursed in full (100 per cent in lieu of 80 per cent).

BLUECHOICE® PPO BENEFITS SUMMARY

PROGRAM BENEFITS	
LIFETIME BENEFIT MAXIMUM	Unlimited.
HOSPITAL BENEFITS	**MEMBER PAYS**
Inpatient [1] *(except behavioral health)* ■ Unlimited days — semiprivate room and board ■ Other hospital-provided services, facilities, supplies and equipment ■ Physical therapy, physical medicine or rehabilitation - up to 45 days per calendar year	$0
Outpatient ■ Ambulatory surgery [1] ■ Surgery [1] ■ Pre-surgical testing (must be performed within 7 days of admission) ■ Chemotherapy and radiation therapy ■ Mammography & cervical cancer screening	$0
Emergency Room/Facility *(initial visit)* ■ Accidental injury ■ Sudden & serious medical condition	$35 Copayment (waived if admitted within 24 hours)
Mental Health [2] ■ Up to 90 days per calendar year	$0
Alcohol/Substance Abuse [2] ■ Up to 7 days detox, up to 30 days rehab per calendar year	$0

(1) Utilization Management Program must pre-approve, except for providers outside the United States.
(2) Behavioral health care management program must pre-approve, except for providers outside the United States.

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BLUECHOICE® PPO BENEFITS SUMMARY

OTHER FACILITY BENEFITS	MEMBER PAYS
Outpatient Alcohol/Substance Abuse(1) ■ Up to 60 outpatient visits which include 20 family counseling visits per calendar year	$0
Home Health Care (2) ■ Up to 200 visits per calendar year	$0
Outpatient Kidney Dialysis ■ Home, hospital based, or free-standing facility treatment	$0
Skilled Nursing Facility (2) ■ Up to 365 days per calendar year	$0
Routine Nursery Care	$0
Hospice (2) ■ Up to 210 days per lifetime	$0

(1) Behavioral health care management program must pre-approve, except for providers outside the United States.
(2) Utilization Management Program must pre-approve, except for providers outside the United States.

BLUECHOICE® PPO BENEFITS SUMMARY

PROGRAM BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
ANNUAL DEDUCTIBLE	$0	$150 Individual $450 Family Maximum
COINSURANCE	$0	20%
COINSURANCE MAXIMUM (Coinsurance Stop-loss)	$0	$900 per Individual (Plus Deductible)
MEDICAL BENEFITS	**In-Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS**
Office/Home Visits	$10 Copayment	Deductible and Coinsurance
Surgical Service	$0	Deductible and Coinsurance
Surgical Assistance	$0	Deductible and Coinsurance
Anesthesia	$0	Deductible and Coinsurance
Inpatient Visits	$0	Deductible and Coinsurance
Consultation Service ■ Office or home *(one per specialty)* ■ Hospital inpatient *(one per admission)*	$10 Copayment $0	Deductible and Coinsurance
Maternity Care	$0	Deductible and Coinsurance
Mammography Screening	$0	Deductible and Coinsurance
Diagnostic X-rays	$0	Deductible and Coinsurance
Lab Tests	$0	Deductible and Coinsurance
Mental Health Care (1) ■ Up to 60 outpatient visits in office or facility ■ Up to 90 professional visits per calendar year while in an inpatient facility	$25 Copayment per visit(2) $0(2)	Deductible and 50% Coinsurance
Chemotherapy & Radiation Therapy ■ Hospital outpatient ■ Physician's office	$0	Deductible and Coinsurance

(1) Combined Maximum for In-Network and Out-of-Network services.
(2) Behavioral health care management program must pre-approve, except for providers outside the United States.

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BLUECHOICE® PPO BENEFITS SUMMARY		
MEDICAL BENEFITS (continued)	**In-Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS**
Second Surgical Opinion	$0	Not Applicable
Ambulance	Not Applicable	$0, Not Subject to Deductible and Coinsurance
Allergy Testing and Treatment	$10 Copayment per visit $0 for testing fees and treatment visits	Deductible and Coinsurance
Diagnostic Screening Tests	$0	Deductible and Coinsurance
Prosthetic & Orthotics, Durable Medical Equipment	$0	Deductible and Coinsurance
Medical Supplies	Not Applicable	$0, Not Subject to Deductible and Coinsurance
Private Duty Nursing (In the home only) $5,000 per year; $10,000 lifetime	Not Applicable	$0, Not Subject to Deductible and Coinsurance
Well Woman Care	$10 Copayment	Deductible and Coinsurance
Annual Physical Exam	$10 Copayment	Not Covered
Well Child Care (including recommended immunizations) ■ Newborn baby - 1 in-hospital exam at birth ■ Birth to 1 year of age - 6 visits ■ 1 through 2 years of age - 3 visits ■ 3 through 6 years of age - 4 visits ■ 7 years until 19th birthday - 6 visits	$0	Deductible and Coinsurance
Chiropractic Care	$10 Copayment	Deductible and Coinsurance
Prescription Drug Card Program	15% Copayment up to a Maximum of $15 per prescription; Mail Order with $10 Copayment	15% Coinsurance (Claim must be filed for reimbursement)
Acupuncture	$10 Copayment	Deductible and Coinsurance
Hearing Aid	Not Applicable	One Exam every three years. (limit $100); one hearing aid per ear every three years

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BLUECHOICE® PPO BENEFITS SUMMARY		
Vision Care	One Exam each 24 months with $5 Copayment: $10 Copayment for Frames; $35 allowance for non-plan eyewear	Not Covered
PHYSICAL THERAPY AND OTHER SKILLED THERAPIES	**In-Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS**
Physical Therapy ■ Up to 45 inpatient visits per calendar year(1) ■ Up to 30 visits combined in home, office, our outpatient facility(1)	$0 in facility $10 Copayment (home or office)	Deductible and Coinsurance
Other Therapies (occupational, speech, hearing, vision) ■ Up to 30 visits combined in home, office, or outpatient facility (1)	$0 in facility $10 Copayment (home or office)	Deductible and Coinsurance
(1) Combined Maximum for In-Network and Out-of-Network services.		

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Discount prescription drug programme (Empire Pharmacy Management)

1. The Blue Cross Empire Pharmacy Management (EPM) discount prescription drug programme is administered by MedImpact. The Empire Pharmacy Management (EPM) programme reimburses at significant savings prescription drugs obtained from participating pharmacies. Under this programme, a retail pharmacy network is provided by Empire Pharmacy Management through MedImpact as well as a mail order facility through Express Pharmacy Services.

2. Significant cost savings are being passed on to participants by utilizing either a participating pharmacy or the Express Pharmacy Services mail order facility. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a brand-name drug be dispensed by indicating "Dispense as written" or "DAW", a generic equivalent drug will be provided by the pharmacist, and the discount off the AWP will average 43 per cent depending on the generic equivalent supplied. The discount for maintenance drugs obtained through Express Pharmacy Services will range from 18 per cent to as high as 50 per cent off AWP, depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

3. The procedure under which prescription drugs is reimbursed through the Empire Pharmacy Management programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice ALONG WITH THE EMPIRE PHARMACY MANAGEMENT CARD (a listing of participating pharmacies in the New York metropolitan area may be found in annex VII). The pharmacist will fill the prescription for up to a 34-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) on the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

4. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through the Express Pharmacy Services mail order facility, which will charge a fixed $10 co-payment per prescription. The Express Pharmacy Services claim form supplied with the Empire Pharmacy Management card should be utilized for ordering maintenance drugs by mail. A new order form will be sent along with the filled prescription. The address and telephone number of the mail order prescription drug facility is as follows:

Express Pharmacy Services
P.O. Box 270
Pittsburgh, PA 15230-9949
Tel. No. (888) 624-5376

5. It should be noted that if a generic equivalent is available and a participant receives a brand-name drug at his or her request even though the physician has not specified a brand-name by indicating "Dispense as written" (DAW) on the prescription, the participating pharmacy and/or the Express Pharmacy Services

mail order facility will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

6. As the Blue Cross BlueChoice prescription drug programme is being administered separately by Empire Pharmacy Management, the normal annual deductible under the BlueChoice plan will NOT be applied to prescription drugs. At the same time, however, prescription drug co-insurance will NOT count towards meeting the annual co-insurance limit of $900. Prescription drugs obtained outside the United States or within the United States but not through the Empire Pharmacy Management MedImpact's participating network will be reimbursed through the submission of a claim form to the claims office at the following address:

Empire BCBS (EPM)
Pharmacy Unit
P.O. Box 5099
Middletown, NY 10940-9099
Tel. No. (800) 839-8442

The special claim form to be utilized for this purpose is available in the offices of the Insurance, Claims and Compensation Section, room S-2765. Claims submitted to the claims office will not be subject to the annual deductible. However, a 15 per cent co-insurance will be assessed on the charges submitted and the $15 limit for each prescription will NOT apply. In addition, the 15 per cent co-insurance will not count towards meeting the annual co-insurance limit of $900.

Other provisions

1. Certain expenses are not covered under the BlueChoice plan. These comprise expenses for services or supplies not deemed by Blue Cross as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Blue Cross as reimbursable under the plan, Blue Cross should be contacted at (800) 377-5156 prior to commencement of treatment. In addition, the Blue Cross policy contract document is on file in the offices of the Insurance, Claims and Compensation Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

2. If Blue Cross denies a claim in whole or in part, the subscriber has the right to appeal the decision. Blue Cross will send written notice of the reason for the denial. The subscriber then has 60 days to submit a written request for review. Blue Cross will send a written decision with an explanation within 60 days of receiving the appeal. If special circumstance require more time, Blue Cross can extend the review period up to 120 days from the date the appeal was received. For a review of a hospital or medical claim, write to:

Empire Blue Cross and Blue Shield
P.O. Box 4606
New York, NY 10163-4606
Attention: Group Accounts

3. Subscribers should note that claims for reimbursement must be submitted to Blue Cross no later than two years from the date on which the medical expense was incurred. CLAIMS RECEIVED BY BLUE CROSS LATER THAN TWO YEARS AFTER THE DATE ON WHICH THE EXPENSE WAS INCURRED WILL NOT BE ELIGIBLE FOR REIMBURSEMENT.

Annex III

HEALTH INSURANCE PLAN OF GREATER NEW YORK/HEALTH MAINTENANCE ORGANIZATION

Plan outline

The HIP/HMO plan follows the concept of total prepaid group practice hospital and medical care, i.e., there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area, including New Jersey and certain areas in Florida. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP/HMO participating pharmacies and are prescribed by HIP/HMO physicians or any physician in a covered emergency. HIP/HMO participants may select a physician at a HIP medical centre or from a new listing of neighbourhood affiliated physicians for primary care services. The affiliated physician is visited in his or her private office. Specialty care, however, will continue to be given in a HIP medical centre based upon the referral of the selected affiliated physician. To select a neighbourhood affiliated physician, the HIP participant should call HIP at (800) HIP-TALK. Additional information regarding this expansion of HIP providers will be provided to participants during the annual enrolment campaign and also mailed by HIP to all participants.

Premium

There will be a 6.0 per cent increase in the total monthly premium of the HIP/HMO plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1998. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

Benefits under the HIP/HMO plan will remain unchanged in the renewal period.

HIP/HMO benefits summary

Type of benefit	HIP/HMO coverage
Hospital services	Covered in full when authorized by HIP/HMO physician

Type of benefit	HIP/HMO coverage
In-hospital physician's services	Covered in full if rendered by HIP/HMO physician
Private duty nursing	Covered in full when authorized by HIP/HMO physician or by any physician in a covered emergency
Skilled nursing facility	No limit on number of days when care is in lieu of hospitalization. Care must be arranged by HIP/HMO physician
Visits to physician's office/ health centre	Covered in full at any HIP/HMO medical centre or if care is rendered by HIP/HMO physician
House calls	Covered in full when authorized by HIP/HMO physician or emergency service programme
Maternity care	No waiting periods. Covered in full when care is rendered by HIP/HMO physician. Prenatal, postnatal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP/HMO physician. Eye examinations are covered in full when rendered by a HIP/HMO physician (eyeglasses and hearing aids are excluded)
Mental health services:	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders
Out-patient	HIP/HMO has its own mental health centres that provide psychotherapy and counselling for adults and children with mental or emotional problems. Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded

Type of benefit	HIP/HMO coverage
Alcoholism and substance abuse:	
In-patient	Covered in full for up to 30 days in any calendar year in a state-certified alcoholism or substance-abuse treatment facility
Out-patient	Medical services for diagnosis and treatment of alcoholism or substance abuse for a period not to exceed 60 visits in any calendar year. HIP/HMO mental health centres will be used for the out-patient services
Emergency services:	
In-area	HIP/HMO has an emergency service programme that is in operation when your medical group is closed. This provides the HIP/HMO subscriber with a 24-hour, 7-day service
Out-of-area	Hospital service: In-patient - covered in full; Out-patient - covered in full, when care is received within 12 hours of onset of illness or within 72 hours (three days) following injury. Doctor services - HIP/HMO pays customary and reasonable non-HIP/HMO physician fees for covered emergency illness or accidental injury
Prescription drugs and medical appliances	$5 co-payment for prescription drugs, but not appliances, when obtained through HIP/HMO participating pharmacies. The drugs and appliances must be prescribed by HIP/HMO physicians, or any physician in a covered emergency
Preventive dental care	Annual cleaning and other preventive dental services performed by a HIP dentist. $5 co-payment per service
Grievance procedure	Refer to member handbook sent to subscribers

Annex IV

KAISER FOUNDATION HEALTH PLAN OF THE NORTHEAST/HEALTH MAINTENANCE ORGANIZATION

Plan outline

The Kaiser Foundation Health Plan is an HMO, providing all medical-related services at Kaiser medical group centres or network affiliates. Services under this plan are accessible to staff members residing in northern Bronx, Westchester County and southern Connecticut. Kaiser health centres accommodate not only physicians' offices but also laboratory, X-ray, pharmacy and mental health services. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. There is no ceiling on the use of authorized services, no deductibles to cover and no insurance forms to complete. The plan coverage emphasizes early detection of medical problems before they become major illnesses.

Premium

There will be a 13.1 per cent increase in the total monthly premium of the Kaiser/HMO plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1998. The relatively high premium increase is due to the high level of losses sustained by Kaiser in the past year. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

Benefits under the Kaiser/HMO plan will remain unchanged in the renewal period.

Kaiser/HMO benefits summary

Type of benefit	Kaiser/HMO coverage
Hospital services	Covered in full when authorized by a Kaiser physician
In-hospital rehabilitation	60 days of in-patient rehabilitation care per condition provided in a hospital or skilled nursing facility
In-hospital physician's services	Covered in full if rendered or authorized by a Kaiser physician

Type of benefit	Kaiser/HMO coverage
Private duty nursing	Covered in full when considered medically necessary
Skilled nursing facility	Covered in full for 100 days per contract year when prescribed, arranged and approved by a Kaiser physician
Visits to physicians' office/health centre	Covered in full at any Kaiser medical centre nationwide or if rendered by or referred by a Kaiser physician
House calls	Covered in full for a registered nurse or Kaiser physician when medically necessary. Limited to the service area
Maternity care	No waiting period. Covered in full when rendered by a Kaiser physician. Prenatal, postnatal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens, twice yearly preventive dental care	Covered in full when rendered or authorized by a Kaiser physician. Preventive dental care for children under 12 years of age only
Alcoholism treatment:	
In-patient	Covered in full for detoxification only
Out-patient	Covered in full up to 60 out-patient visits per calendar year for the diagnosis and treatment of alcoholism
Mental health services:	
In-patient	Covered in full for 30 days per contract year
Out-patient	Covered in full at Kaiser Medical Center for short-term evaluation or crisis intervention for visits 1-10 per contract year. Visits 11-20 are covered subject to a 25 per cent co-insurance of the Kaiser fee-for-service rate. Visits 21-30 are covered at 50 per cent of the Kaiser fee-for-service rate

Type of benefit	Kaiser/HMO coverage
Emergency services:	
$25 co-payment	A $25 co-payment will be assessed for emergency care services. Immediate notification to Kaiser required if admitted to a hospital (or within a reasonable period of time if incapacitated). Out-patient emergency care requires 48-hour notification to Kaiser, i.e., within 48 hours after the care is received
In-area	Covered in full for life-threatening conditions for care received in a hospital emergency room. Kaiser must be notified first, if possible, or, if not possible, within 48 hours of treatment
Out-of-area	Covered in full for reasonable charges for sudden onset of an illness or accident requiring immediate attention. Kaiser must be notified within 48 hours
Prescription drugs and medical appliances	$3 co-payment for all prescriptions prescribed by Kaiser physicians and obtained at Kaiser pharmacies. Durable medical equipment is covered in full. Coverage is provided for internal prosthetic devices and for their replacement
Grievance procedure	Refer to member handbook sent to subscribers

Annex V

CIGNA DENTAL PPO PLAN

Background

Following the conduct of a competitive request-for-proposal (RFP) exercise earlier this year, and in light of the results of a dental plan attitude survey carried out among staff and retirees of the United Nations, UNDP and UNICEF, it was decided to change the dental insurance programme at Headquarters from the GHI plan to a new dental preferred provider organization (PPO) plan administered by CIGNA. The selection of CIGNA as administrator of the new plan was made after careful review and analysis of the proposals received, based on key evaluation criteria relating to overall servicing capacity, ability to accommodate the requested plan design, and the size and geographic dispersion of the provider network, among other important criteria.

Plan outline

The design of the CIGNA Dental PPO plan offers staff not only a **larger network** of participating providers in the greater New York metropolitan area than heretofore, but also **two distinct plan options, OPTION A and OPTION B**, while retaining a single premium structure. The dual option structure is designed to ensure (a) that staff members who found the GHI type of plan satisfactory may continue to have the costs of dental treatment for themselves and their family members handled in the same way as before, and (b) that those staff members whose dental treatment is not rendered by network (or participating) dentists, will now have the option of selecting a track which reimburses on the basis of a percentage of "reasonable and customary" dental fees, in much the same way as do the Aetna and Blue Cross PPO health plans.

All staff members currently enrolled in the GHI plan will automatically be enrolled in the new CIGNA plan under OPTION A as this option corresponds to the traditional plan structure. All participants will have the opportunity to elect **OPTION B** if they feel that this option is more advantageous to them. It is essential to note, however, that the option selected will apply to all covered family members as well. It is not possible, for example, for a staff member to retain OPTION A and for the staff member's spouse to select OPTION B. Furthermore, in order to give staff members sufficient time to make their decision should they not feel in a position to do so during the annual campaign week, OPTION B may be chosen at any time up to 31 August 1998. Thereafter, staff members must wait until the 1999 enrolment campaign to select OPTION B should they so wish. **There is a special CIGNA form, to be transmitted through the Insurance, Claims and Compensation Section, for selecting OPTION B.** This form will be available during the enrolment campaign at the CIGNA desk in the Secretariat lobby area, and at the offices of the Insurance, Claims and Compensation Section, room S-2765.

CIGNA identification cards

CIGNA identification cards will be issued before the plan's effective date of 1 July 1998. Please note that the CIGNA ID card does not indicate the option selected. The selection of either Option A or Option B is recorded in CIGNA's

database and will be known to a provider at the time that coverage eligibility is checked by the provider's office. A subscriber's CIGNA ID number will be comprised of nine digits. The first three, to be assigned by CIGNA, will be common to all UN subscribers. The last six digits will be the staff member's index number.

Premium

The monthly premium schedule for the CIGNA Dental PPO plan will be the same as the current monthly premiums of the out-going GHI plan. The premiums and related percentages of salary contribution for the CIGNA plan are shown on page 2 of this circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organizations's subsidy towards the cost of that coverage, which is shown as a credit. The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the Organizational subsidy.

Description of Option A and Option B

Option A:

Option A is similar to the GHI plan design in that it provides for 100 per cent coverage without any deductible if the dental treatment is rendered by a dentist participating in the CIGNA provider network. The CIGNA participating provider network is nationwide, and includes a total of over 38,000 dentists, with approximately 4,800 in New York State (3,000 in New York City), 2,100 in New Jersey and 700 in Connecticut.

Participants who choose Option A may also visit non-participating (or non-network) dentists and will be reimbursed the CIGNA in-network fee contracted with participating dentists who practice in the same area as the non-participating dentists. If the non-network dentist's fee is higher than the contracted in-network fee, the difference will be payable by the participant. It is important to note that, under the CIGNA plan, there is no single PPO contracted fee schedule as is the case with the GHI plan. The contracted fee levels vary in accordance with prevailing costs in the different areas in which the dental practices are located.

A chart summarizing the OPTION A benefits and reimbursement levels is set out on page 42.

Option B:

The key feature of Option B is the reimbursement allowance formula for participants who wish to utilize non-network dentists. Under this option, out-of-network dental treatment will be reimbursed at certain percentage levels after an annual deductible of $25 per person or $75 per family has been met. The percentage reimbursement levels apply to the "reasonable and customary" dental fee levels prevailing in the dentists's zip-code area. Reasonable and customary fee levels are determined by reference to a national database maintained by the Health Insurance Association of America (HIAA). The percentage reimbursement rate depends on the

level of dental treatment as follows: 90 per cent for preventive/diagnostic treatment; 80 per cent for major and minor restorative treatment; 70 per cent for orthodontics.

Under Option B, participants may also be treated by in-network dentists. In this case there is no deductible. The reimbursement percentages for preventive/diagnostic care, major and minor restorative treatment and orthodontics are 100 per cent, 90 per cent and 80 per cent, respectively, based on the network provider's contracted fee level with CIGNA. Thus the amount payable by the participant will be the difference between the 90 or 80 per cent reimbursement and the CIGNA contracted PPO fee for the service provided.

A chart summarizing the OPTION B benefits and reimbursement levels is set out on page 43.

Dental treatment outside the United States

Participants who obtain dental treatment outside the United States may file their claims with CIGNA and are eligible for reimbursement on the same basis as a participant who visits a non-participating dentist in New York.

Maximum annual benefits

The annual benefit ceiling is $2,000 per covered person, and is the same whether Option A or Option B is selected. There is an additional lifetime allowance of $2,000 for orthodontic treatment, limited to dependent children up to 19 years of age.

Pre-treatment review (pre-determination of benefits)

If a course of treatment can reasonably be expected to involve covered dental expenses of $300 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with CIGNA before the course of treatment begins. The dentist should be sure to include the American Dental Association (ADA) procedure code for each procedure claimed.

CIGNA provider directories

CIGNA provider directories for the NY metropolitan area will be available during the campaign week at CIGNA's desk in the Secretariat lobby area, and thereafter at the offices of the Insurance, Claims & Compensation Section, room S-2765.

CIGNA Worldwide Website

Access to CIGNA's nationwide network of participating dentists will also be available from 1 July 1998 through the Insurance home page on the UN Intranet. In the meantime, the CIGNA dental provider directory can be accessed directly from CIGNA's Internet website, www.cigna.com/dental.

OPTION A

Summary of Benefits

CIGNA Dental PPO

Benefits	*In-Network **		*Out-of-Network **	
Plan Year Maximum - 1 July 1998 - 30 June 1999 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible	None		None	
Reimbursement Levels	Based on reduced contracted fees		Based on In-Network reduced contracted fees	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I - Preventive & Diagnostic Care Oral Exams (Two per year) Cleanings (Two per year) Full Mouth X-rays (One complete set every three years Bitewing X-rays (Two per year) Panoramic X-ray (One every three years) Flouride Application (One per year for persons under 19) Scalants (Limited to posterior tooth for a person less than 14/One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class II - Basic Restorative Care Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class III - Major Restorative Care Crowns Dentures Bridges	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class IV - Orthodontia	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Lifetime Maximum (In addition to the Class I, II and III maximum)	$2,000 Dependent children to age 19		$2,000 Dependent children to age 19	

Pre-treatment review (pre-determination of benefits) is recommended when dental work in excess of $200 is proposed. The dentist deals directly with CIGNA in this regard.

* The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network.

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OPTION B

Summary of Benefits
CIGNA Dental PPO

Benefits	*In-Network* *		*Out-of-Network* *	
Plan Year Maximum - 1 July 1998 - 30 June 1999 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible - 1 July 1998 - 30 June 1999				
Individual	None		$25 per person	
Family	None		$75 per family	
Reimbursement Levels	Based on reduced contracted fees		Based on Reasonable & Customary Allowances	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I - Preventive & Diagnostic Care Oral Exams (Two per year) Cleanings (Two per year) Full Mouth X-rays (One complete set every three years Bitewing X-rays (Two per year) Panoramic X-ray (One every three years) Flouride Application (One per year for persons under 19) Scalants (Limited to posterior tooth for a person less than 14/One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	90%	10%
Class II - Basic Restorative Care Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	90%	10%	80% **	20% **
Class III - Major Restorative Care Crowns Dentures Bridges	90%	10%	80% **	20% **
Class IV - Orthodontia Lifetime Maximum (In addition to the Class I, II and III maximum)	80% $2,000 Dependent children to age 19	20%	70% ** $2,000 Dependent children to age 19	30% **

Pre-treatment review (pre-determination of benefits) is recommended when dental work in excess of $200 is proposed. The dentist deals directly with CIGNA in this regard.

* The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.

** Subject to plan year deductible.

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Benefit Summaries

The benefit summaries on pages 42 and 43 highlight the many benefits which are available under the CIGNA Dental PPO plan. A complete description regarding the terms of coverage, exclusions and limitations will become available following implementation of the plan.

How to appeal a claim

If you do not agree with the reason given for denial of your claim in whole or in part, you should write within 60 days to the CIGNA claims office. Be sure you state why you believe the claim should not have been denied and submit any data, questions or comments you think are appropriate. Your appeal will be reviewed by the office that processed your claim. Any appeal that cannot be resolved by that office will be forwarded to the company's Home Office for review and final decision. You will be notified of the final decision within 60 days of the date your appeal is received, unless there are special circumstances, in which case you will be notified within 120 days. If you are not satisfied with the final decision, and you wish to review the documents pertinent to any appealed claim, you should write to the office that processed your claim.

Benefit exclusions:

The following list, while not necessarily complete, gives examples of benefit exclusions:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made useable according to dental standards
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- Surgical implant of any type including any prosthetic device attached to it
- Instruction for plague control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Charges which the person is not legally required to pay
- Experimental or investigational procedures and treatments
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances

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Annex VI

WORLD ACCESS

World Access (formerly known as Access America) is a facility available to Aetna and BlueChoice subscribers. The $0.25 per month per subscriber cost of the World Access facility is built into the premium schedule for Aetna and BlueChoice set out on page 2 of the present circular.

World Access provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad, or within the United States, when at least 100 miles from one's normal place of residence. Participants who call the hotline numbers below will, where possible, be provided with referrals from a worldwide network of physicians, dentists, hospitals, pharmacies and other medical facilities. In addition, in most cases, World Access will settle the costs of EMERGENCY foreign hospital admission and treatment. If the emergency hospitalization occurs in the United States and the hospital does not accept the Aetna or the Blue Cross BlueChoice identification cards, World Access will also settle the related costs directly with the hospital and then claim reimbursement directly from Aetna or Blue Cross as the case may be. In the case of hospitalization, World Access medical staff will contact the insured patient's local physician in order to monitor the case and services being received. In the event of an emergency hospitalization in the circumstances described above, it is important that World Access be contacted upon admission to the hospital or, at the latest, before discharge. It should also be emphasized that any hospital bill paid by the participant must be sent to Aetna for reimbursement or Blue Cross, as World Access does not reimburse participants directly.

The hotline numbers are:

(800) 654-1901 - (in the United States, Canada, Puerto Rico and the Virgin Islands)

(804) 673-1159 - collect (from Alaska, Washington, D.C. and all other locations), or

Fax No. (804) 673-1179

When contacting World Access, be sure to identify yourself as a United Nations participant. Please state the World Access identification number for the United Nations, which is 2065, in addition to your UN index number.

Annex VII

AETNA AND BLUE CROSS PLANS
LIST OF PARTICIPATING PHARMACIES

Set out below are lists of the major participating chain pharmacies under the Aetna and Blue Cross discount prescription drug programmes. The Aetna and Blue Cross directories of participating pharmacies are available at the offices of the United Nations Insurance, Claims and Compensation Section; the Division of Personnel, UNDP; and the Office of Personnel, UNICEF. In addition, if a participating pharmacy is needed while traveling, referral information is available from Aetna ((888) 792-8742) and Blue Cross ((800) 839-8442).

Aetna Participating Chain Pharmacies

New York	New Jersey	Connecticut
AARP Phcy Service	ACME Phcy	AARP Phcy Service
A & P Phcy	A & P Phcy	A & P Phcy
Brooks Drug	Brooks Drug	Arrow Prescription Ctr
Caldor Phcy	Caldor Phcy	Arthur Drug Stores
Costco Phcy	Clover Phcy	Brooks Drug
CVS	Costco Phcy	Caldor Phcy
Drug Mart	CRX Phcy	Costco Phcy
Drug World	CVS	CVS
Duane Reade	Drug Fair	Douglas Drug
Edwards Phcy	Drug World	Edwards Phcy
Fay's	Duane Reade	F & M Distributors
Finast Phcy	Eckerd Drugs	Genovese
Freddy's	Food Town Phcy	Grand Union Phcy
Genovese	Foodmax Phcy	K Mart Phcy
Grand Union Phcy	Genovese	The Medicine Shoppe
Great American Drug	Grand Union Phcy	NPSC/EPIC
K Mart Phcy	Happy Harry's	Pathmark Phcy
King Kullen Phcy	K Mart Phcy	Purity Phcy
Kinney Drugs	The Medicine Shoppe	Rite Aid
Leroy Phcy	Pathmark Phcy	Shop Rite Phcy
The Medicine Shoppe	Phar-Mor	Super X Drug Store
Pathmark Phcy	Pharmhouse	The RX Place
Peterson Drug Co.	Quick Check	Shop & Stop
Phar-Mor	Revco	Waldbaum's Phcy
Pharmhouse	Rite Aid	Walgreens
Price Chopper Phcy	RXD Phcy	Wal-Mart
Revco	Sav-On	Woolworth Phcy
Rite Aid	Shop Rite Phcy	
Rockbottom Phcy	Super X Drug Store	
Shop'N Save Phcy	The RX Place	
Shop Rite Phcy	Thrift Drug	
The RX Place	Thrift RX	
Shop & Stop	Waldbaum's Phcy	
Thrift Drug	Walgreens	
Tops Phcy	Wal-Mart	
Vix Phcy	Woolworth Phcy	
Waldbaum's Phcy		
Walgreens		
Wal-Mart		
Wegmans Phcy		
Weis Phcy		
Woolworth Phcy		

Blue Cross Participating Chain Pharmacies

A & P
Brooks Phcy
Costco
CVS
Drug Mart
Duane Reade
Eckerd
Edwards
Finast
Foodtown
Freddy's
Genovese
Grand Union
JC Penney Prescription Ctr
K Mart
Phar-Mor
Pharmhouse
Price Chopper
Price Club
Revco
Rite Aid
Safeway
Sav-On
Shop'N Save
Shoprite
SupeRx
Target
The Medicine Shoppe
Thrift Drug Store
Tick Tock Drugs
Tops
Vons
Wal-Mart
Waldbaum's
Walgreens
Weis

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Annex VIII

INSURANCE CARRIER ADDRESSES AND TELEPHONE NUMBERS FOR CLAIMS AND BENEFIT INQUIRIES

I. AETNA OPEN CHOICE PLAN (medical and out-of-network pharmacy claims)	Aetna Life Insurance Company Unit 73 3541 Winchester Road Allentown, PA 18195-0501
Tel.: (800) 784-3991	Member Services (benefit/claim questions)
Tel.: (888) 792-8742	Participating pharmacy referral
Tel.: (888) 792-8742	Walgreen's Customer Service (mail order drugs)
Tel.: (888) 792-8742	Maintenance drug automated refills (by credit card)
Tel.: (800) 424-1601	Focused Psychiatric Review (FPR)
Tel.: (800) 793-8616	Vision One
II. BLUE CROSS BLUECHOICE PLAN	Empire Blue Cross 622 Third Avenue New York, NY 10017
Tel.: (800) 377-5156	Member Services (benefit/claim questions)
Tel.: (800) 982-8089	Utilization Management Program (pre-certification for hospital admissions, elective surgery, home care, skilled nursing facilities and second opinion referrals
Tel.: (800) 626-3643	Behavioral Health Care Management Program (prior approval of mental health/substance abuse care
Tel.: (888) 624-5376	Express Pharmacy Services, Inc. (maintenance drug mail order)
Tel.: (800) 839-8442	Empire Pharmacy Management Programme/MedImpact (prescription card programme and pharmacy network information)
III. HIP/HMO Tel.: (800) HIP-TALK ((800) 447-8255)	HIP Member Services Department 7 West 34th Street New York, NY 10001
IV. KAISER/HMO Tel.: (800) 305-1998	Kaiser Foundation Health Plan 210 Westchester Avenue White Plains, NY 10604
V. CIGNA DENTAL PPO PLAN Tel.: (800) 355-5965 (claim submission and Customer service) Tel.: (888) DENTAL8 (for participating provider referrals)	Cigna Healthcare Service Center P.O. Box 182539 Chattanooga, Tn. 37422-7539